

- Branding Yourself and Your Urology Practice: Sculpting Your Practice by Attracting the Patients You Would Like to Treat
- Understanding the Implications of Medicare's Physician Value-Based Modifier

11:50 PM to 12:50 PM

Industry-sponsored lunch.

LUGPA Annual Business Meeting

When the Government Comes Knocking: Best Practices for Protecting Your Group from the Unannounced Federal or State Investigator

LUGPA Partnership in Leadership Series Sponsored by Dendreon (Seattle, WA)

The Honorable Scott Walker
(R-WI)
Governor, Wisconsin

5:00 PM to 6:00 PM

Welcome reception.

7:00 PM to 8:30 PM

Industry-sponsored dinner.

Saturday, November 8, 2014

6:55 AM to 7:55 AM

Industry-sponsored breakfast. Options for Independent Practice, Michael Blau, JD, Foley and Lardner, LLP (Boston, MA).

Breakout Sessions

- Maximizing Advanced Practice Providers in a Urology Practice

- International Classification of Diseases (ICD-10): Update for Urology
- Mergers and Acquisitions, Legal, and Reimbursement Considerations
- Challenging Practice Scenarios (Open Mic)
- Why Have a Men's Health Clinic?

11:00 AM to 12:30 PM

Industry-sponsored lunch.

12:30 PM

Adjournment.

Keep an eye out for Annual Meeting updates and be sure to check the Web site for meeting information. I look forward to seeing you in November! ■

The Obama Administration: Driving Provider Consolidation and Increased Costs

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The increasing consolidation of health care providers has undeniable, deleterious consequences for consumers; yet what is the Obama Administration doing about it? Making things worse.

A *New England Journal of Medicine* study by Kocher and Sahni¹ asserted that "US hospitals have responded to implementation of health care reform by accelerating hiring of physicians.

More than half of practicing US physicians are now employed by hospitals or integrated systems, a trend that is fueled by the intended creation of accountable care organizations."

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Hospitals that acquire physician practices argue that it helps them coordinate care and control costs. But why are hospitals often acquiring physician practices for a price that is far in excess of what they can possibly bill? It seems irrational.

They do so to capture the referrals for all types of services. Kocher and Sahni¹ state, "For hospitals to break even, newly hired PCPs must generate at least 30% more visits, and new specialists 25% more referrals, than they do at the outset... Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities."

A May 2014 *Health Affairs* study² also found that when hospitals buy physician practices, the result is higher hospital prices and increased spending. The study, performed by Stanford University (Stanford, CA) researchers, examined 2.1 million hospital claims and validates insurance companies' and economists' contentions that the main motivation is negotiating higher prices and capturing referrals.

Researchers at the Center for Studying Health System Change (Washington, DC) examined nearly 600,000 private insurance claims and found that average hospital outpatient department prices for common imaging, colonoscopy, and laboratory services are double the price for identical services provided in physician offices or other community settings. For example, the average price of a colonoscopy in a hospital was \$1383, compared with \$625 in a community setting (eg, ambulatory surgery center). Similarly, physical therapy prices were 41% to 64% higher in hospitals than community settings.³

The Federal Trade Commission has only sporadically engaged on such mergers and acquisitions. For example, it blocked a proposed

merger in Idaho that would have given Boise-based St. Luke's Health System 80% of the physicians in Nampa, Idaho.

The Medicare Payment Advisory Commission has recommended that Medicare pay hospital-employed physicians for routine evaluation and management visits at the same rate as physician offices. Such a policy would reduce hospital reimbursement for those services by over 56%, and save more than \$10 billion over 10 years. Congress has not acted on that recommendation, nor has the Administration endorsed it.

Indeed, increasing payment disparities between the physician office and hospitals for identical services appears to be a deliberate public policy of this Administration, and has made it difficult for physician practices to remain economically viable. Payment cuts to cardiology for services often provided in the office more than tripled the number of cardiologists employed by hospitals between 2007 and 2012. Now the Centers for Medicare and Medicaid Services proposes eliminating reimbursement for the "radiation treatment vault," which protects health care professionals, caregivers, and others from such radiation and is integrally tied to the linear accelerator itself. If this proposal is finalized, payments to physician-led community-based centers would be cut by more than 10% but leave hospitals untouched.

It should be no surprise that such policies have discouraged many physicians from continuing to operate free-standing practices. A recent study by Merritt Hawkins & Associates (Irving, TX) found a substantial shift toward the employed physician model, with more than 90% of new physician job openings at hospitals and other facilities and just 10% in independent practice settings.⁴

Obama Administration's Proposal on Self-referral Unfounded and Drives Care to Hospitals

Despite these alarming trends and cost implications to the health care system, the Obama Administration offered a proposal that would make it illegal for integrated physician practices to provide "ancillary services" such as advanced imaging, radiation therapy, anatomical pathology, and physical therapy. The President's budget proposed to eliminate the so-called "in-office ancillary services exception" (IOASE) provision that allows integrated physician practices to incorporate these services.

The Administration argues that the IOASE provision has encouraged overutilization because physicians consume more resources when they refer services to their own practices. A series of Government Accountability Office (GAO) reports supports that narrative, at first glance; however, a closer look at the data offered by GAO and analysis of all of Medicare claims since 2007 contradicts the assertion that physician-led care has resulted in overutilization.

Advanced Imaging

Utilization of advanced imaging, which has drawn the most focus of self-referral opponents, has actually declined in the physician office recently. Medicare spending for computed tomography and magnetic resonance imaging services dropped from \$4.1 billion in 2007 to \$3.7 billion in 2012, and preliminary data indicate a drop to \$3.5 billion in 2013. More than 75% of these services are provided in the more expensive hospital setting.⁵

Radiation Therapy

In its report on radiation therapy, the GAO observed that although

utilization of intensity-modulated radiation therapy (IMRT) services for prostate cancer increased by self-referring groups, it was offset by decreases within hospitals and non-self-referring groups. “Overall utilization of prostate cancer-related IMRT services therefore remained relatively flat across these settings.”⁶

Physical Therapy

The GAO found that “from 2004 to 2010, non-self-referred physical therapy (PT) services increased at a faster rate than self-referred PT services. During this period, the number of self-referred PT services per 1000 Medicare fee-for-service beneficiaries was generally flat, whereas non-self-referred PT services grew by about 41%.”⁷

Prostate Biopsy

A recent study on in-house pathology utilization of prostate biopsies that reviewed 4.2 million specimens between 2005 and 2011 demonstrated no significant difference in both the positive biopsy rate and utilization trends between physician-owned laboratories and a national reference laboratory.⁸

If physician practices are prohibited from offering these services through legislative fiat—as the Obama Administration

proposes—this care will be forced into the more expensive and less convenient hospital setting. This radical proposal has sparked alarm and outrage in the physician community. A coalition of more than 30 specialty physician groups, and the American Medical Association, representing hundreds of thousands of physicians, wrote Congress to object to this proposal, stating that it would undermine the viability of the independent physician practice model and “result in further centralizing of care around a few dominant hospital systems, which will undermine competition and in turn raise costs to the entire health care system over the long term.”⁹

Most Republicans have been unwilling to dictate how physicians should structure their practices or where care should be delivered. But the proposal has drawn interest from some Democrats, who view it as appropriate to helping finance a long-term solution to pending Medicare physician cuts and other priorities. Although hospitals have not actively lobbied for the proposal, they certainly prefer it over further hospital cuts, such as site-of-service payment neutrality. That makes it a viable threat and just one more catalyst to further consolidation, which will only raise costs for consumers.

It is time to step back and take a broader view of health care policy. Where should most elective health care take place, the hospital or community setting? And what policies should be pursued to reverse the current trend? ■

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